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AN EXPERIMENTAL LIVING UNIT IN A UNIVERSITY SETTING, A NEW APPROACH TO THE REHABILITATION OF THE EMOTIONALLY DISTURBED STUDENT.

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BECAUSE TYPICAL UNIVERSITY RESOURCES SEEMED INADEQUATE FOR WORKING WITH SEVERELY EMOTIONALLY DISTURBED STUDENTS, KANSAS STATE UNIVERSITY ESTABLISHED A HALFWAY HOUSE OR THERAPEUTIC COMMUNITY AS A PREVENTIVE MEASURE IN FEBRUARY 1966. A RESIDENCE HALL WAS UTILIZED AND REGULAR RESIDENTS WHO VOLUNTEERED AS PROJECT PARTICIPANTS WERE INSTRUCTED ON COPING WITH PROBLEMS. EQUAL NUMBERS OF EMOTIONALLY DISTURBED STUDENTS AND RESIDENCE HALL VOLUNTEERS COMPRISED THE 10 MEN AND 10 WOMEN PARTICIPATING. REGULAR GROUP MEETINGS, SPONTANEOUS GROUP MEETINGS TO HANDLE CURRENT INTENSE PROBLEMS, ENCOURAGEMENT OF OPEN AND HONEST RELATIONSHIPS, USE OF CONFRONTATION IN DEALING WITH DEVIATE BEHAVIOR, AND OPPORTUNITIES FOR COUNSELING HELPED THE PARTICIPANTS TO GAIN SELF-INSIGHT. ALL PARTICIPANTS RANKED INFORMAL CONTACT WITH EACH OTHER AS THE MOST IMPORTANT SOURCE OF HELP. TIME HAS BEEN TOO SHORT FOR EVALUATION, BUT NONE OF THE PARTICIPANTS DROPPED OUT AND LESS USE WAS MADE OF OTHER THERAPY. FOLLOWUP STUDIES ARE UNDERWAY. AN UNANTICIPATED VALUE HAS BEEN SOLIDIFYING OF THE DIVERSE MENTAL HEALTH RESOURCES OF THE UNIVERSITY AND SELF-EVALUATION WITHIN THE VARIOUS STUDENT PERSONNEL SERVICES. (TU)

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August, 1966

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WHAT TO DO WITH THE DISTURBED?

The counselor, working in conjunction with other professional staff in a university setting, is often faced with participating in important life decisions with and on behalf of students who have severe emotional disturbances. In helping this problem group we faced the perplexing question: "Are the typical resources (counseling or psychotherapy, chemotherapy, brief inpatient care in a Student Health Service) sufficient to maintain these students functioning in college?" What alternatives are there when professional staff are doubtful whether the student can be effectively helped with the resources available on campus?

One choice that most counselors have tried is "taking their chances" in working as part of a loosely organized team to help the potentially suicidal, the borderline schizophrenic, and the severe neurotic. While this course of action can lead to legitimate worrying and apprehension on the part of the staff involved, the other alternatives also contain costly risks for the student.

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The "send-them-home" therapeutic approach is often a poor choice for a number of reasons. Uprooting the student from the university community is in itself a disruptive experience. Then, too, for the late adolescent, parents may be more a source of conflict than a source of support. Moreover, many of our students -- as in most other land grant colleges -- have their homes in small towns or rural areas with less adequate rehabilitation facilities than those provided on the campus.

The alternative of in-patient hospital treatment involves the likelihood of the student's seeing himself as incompetent, as sick and unable to cope with his problems. Remaining in college appears to be a last source of positive self-regard for some students.

In terms of the effects on vocational preparation, psychiatric hospitalization or a return home may at best prolong the client's education, thereby reducing his productive years or lead to his being employed at a level either below his capacities or incompatible with his interests. We know, too, that some members of this group can continue to produce scholastic work of very high quality even when undergoing great despair. For example, a psychologist was working with a student who was severely depressed and showed some disorganization in his thinking. He had made one serious suicidal attempt and continued to be preoccupied with ideas of suicide. The faculty member who referred him recognized that he needed help but added "I sure hope you can help him -- he's the best student I have ever had."

One other consideration should be raised: professionals experienced in working with the late adolescent age group are familiar with the instability of diagnosis and presenting symptoms and with the uncertainty of prognostic judgments for these clients. Severe distress and disorganization which are transient, and dramatic responses to treatment are

not uncommon. Intervention is clearly needed, but transitory crises should not require a major interruption of the educational program.

THE INCIDENCE OF EMOTIONAL DISABILITY IS SIGNIFICANT

What is the incidence of psychological disturbance among college students? Estimates of about ten per cent are common.[1] For those students seen in a counseling setting such as ours, twenty per cent is a representative figure. How many students might need a specialized intensive service such as we propose? In response to this query, our staff nominated approximately fifty cases for each of the last two academic years. This segment represents about five per cent of the Counseling Center caseload of 900-1000 students.

A follow-up of these nominees has shown that in spite of both average academic aptitude and average achievement, the incidence of drop-outs has been fifty per cent per year. This attrition rate compares very unfavorably with that of students in general for whom the attrition rate is forty-eight per cent over <u>four</u> years.

A previous local study of students-in-general[2] found that the number of students actually dismissed for low grades was small: seventeen and one-half per cent. Moreover, the grade point averages of these drop-outs were not remarkably low: forty-eight per cent had a C- average or higher and, at that time, if maintained, their level of performance would have been sufficient for graduation. Personal problems and vocational uncertainty ranked high among reasons indicated for leaving the university, and certainly some of the difficulties in study and poor motivation so frequently reported by these students are a product of emotional disturbance. Complaints such as these are typical presenting problems among those with disabilities from emotional causes.

WE PLANNED AN EXPERIMENTAL LIVING UNIT

In attempting to cope with the problems repeatedly confronting us in providing assistance to the emotionally disturbed student, our Counseling Center staff began searching for solutions other than those traditionally offered.[3] As we contemplated various innovative approaches, we became intrigued with the possibility of adapting the halfway house model as a rehabilitation service. Our conception was that of a preventive halfway house[4] rather than that of restoring a person from an institution to society. By means of a VRA planning grant[5] we were enabled to visit selected halfway houses. The two programs which had the most influence on us were Wellmet House[6] and Woodley House.[7] A conference was held to assist us in adapting the halfway house approach to use in a university setting as well as to plan follow-up research and a study of the social-psychological aspects of the rehabilitation processes in a living unit.

In response to recommendations by our consultants we visited two therapeutic community programs:[8] Praire View Hospital and Fort Logan Mental Health Center. These visits stimulated us to refine our planning to incorporate therapeutic community approaches. In the final stages of our planning, the granting agency requested us to establish our living unit in an existing university residence hall rather than to operate as an autonomous unit off campus. A visit to the Nebraska Psychiatric Institute's boarding house program[9] gave us some helpful ideas in implementing this request.

A final refinement was the decision to select some of the residents in the residence hall as project participants. We felt this would circumvent a rejection problem concerning the emotional disturbed often

seen in the residence halls. Deviate behavior, although pardonable initially, ultimately elicits rejection, hostility, or anxiety in others. Such rejection obviously undermines further the security and self-esteem of the distressed student. We attempted to prepare the selected residents to anticipate and to cope with such disturbing behaviors.

In February, 1966, we began with our first group of students. The disturbed students were selected from a pool of over thirty-two clients nominated by counselors and our consulting psychiatrist.

The physical setting of the unit was the first floor of a small, older university residence hall close to the main campus. Two apartments for men and two for women were used. The first floor was used because both sets of apartments and the main entrance were all adjacent to the common lounge. The dormitory director's office was situated near the female quarters so that supervision was adequate. The capacity of the unit was ten males and ten females. Half of each of these groups were clients and half were volunteers. Meals were taken in the dining hall with the other forty students living in the hall.

The experimental living unit students participated fully in the residence hall programs, attending meetings, holding office, serving on committees, and participating in the hall intramural sports and social activities. The project itself soon came to be popularly called "The Waltheim Project" after the name of the residence hall.

But how is a therapeutic community or milieu created within a university residence hall? We reasoned that the central aspect of our treatment program was to be the intimate daily interaction among the residents, that the students themselves would be the principal source of help. As noted above, ecological features of the setting facilitated interaction.

We chose not to impose pre-planned rules and structures, on the assumption that the task of developing cooperative problem-solving relationships is basic to the establishing of a therapeutic community. From having observed the operation of Wellmet House we felt that normal student volunteers might be one of our chief agents of change. However, we have chosen to minimize the differences between the helped and the helping, assuming that all members of the therapeutic community both give and receive. The differences in some instances were so minimal that even our neutral observers and some project staff misidentified helped and helper. Another important difference between our program and that of Wellmet is that our clients and volunteers were currently enrolled as students and were peers in age and socioeconomic status while at Wellmet there were marked differences between students and clients in age, intellectual level, and socioeconomic status. Our clients were also less severely disturbed than those typically resident in a halfway house because our clients had to be sufficiently integrated to continue as students.

Additional staff were provided for the living unit above the normal coverage furnished by the university for the residence hall: a part-time female assistant residence hall director and a male graduate student in Sociology who lived in the mens quarters as a participant observer. We anticipated, correctly, that there would be crises similar to those reported in the literature on residential treatment,[10] and we felt responsible to provide personnel to cope therapeutically with such critical events. Two of the authors, one a clinical psychologist and the other a counseling psychologist, were available to assist in intervention. We have come to feel that some of the small spontaneous group meetings which we named ad hoc groups, oriented around

a current, intense problem were very beneficial. For example:

> Teresa's cousin, Angela, phoned me saying that Teresa had come to her apartment crying and very upset. It was evident that Angela herself felt frightened and concerned about what Teresa might do. I asked if Angela could bring Teresa to my home. Teresa was crying profusely and showing diffuse anxiety. If she had not resided in the living unit my efforts would have been oriented toward support and preparing her and making arrangements for hospitalization at Student Health.
>
> She complained bitterly that no one in the unit would talk to her or listen to her to alleviate her distress. I asked if she would return to the unit to talk about this with her roommates. The meeting revealed that others felt that Teresa was communicating that she wanted to be left alone. Both Teresa and her roommates reflected about their contribution to the problem (misreading of cues, not communicating distress signals) and I felt this process opened the way for Teresa to be better able to find help for herself from her peer group. If she had lived in an ordinary dormitory, I would not have attempted to use the group in this manner.

In addition to extra personnel, to the use of normal volunteers, and to the spontaneous ad hoc group meetings, regular weekly group meetings of the experimental unit as a whole were held. These meetings, oriented primarily toward problems in group living, have been important in establishing the unit as a therapeutic community.

While every client in the unit had regular continuing counseling appointments in the University's Counseling Center, counseling services to the volunteers were available at the student's own request. Two of the project research staff alternated in providing one hour per day in consultation to the entire unit in an office in the residence hall. Their time was used by the residence hall staff, by volunteers, or by clients. It should be emphasized that the living unit was used as an additional rehabilitation resource rather than as a substitute for conventional services. Medical and psychiatric consultation

were available to staff and students as part of the project in addition to the routine services available to all university students.

DOES THE LIVING UNIT WORK?

After one semester of operation our number of cases and the length of follow-up are both too limited for a definitive answer. We have noted that none of our clients dropped out during the semester. Also their grades were approximately the same as those obtained by the volunteers. It seemed, too, that we made less use of brief hospitalization and chemotherapy for the clients in the unit when compared with their previous use of these services. Counselors have come to view the unit as an additional resource. It is our impression that the counseling interviews with the unit residents are more intense than with clients not in the unit. Project members seem much more concerned with current interpersonal relations than they are with memories, past events, and fantasies. Some schizoid clients feel threatened by the intense interaction; yet it seems that they make progress in establishing and maintaining social relationships. The coed living situation has created opportunities that might not otherwise exist for casual relationships among the sexes. This condition facilitates mature social behavior and has favorably affected the conduct of the total residence hall population.

Some of the preliminary research findings offer support that we were indeed successful in establishing a therapeutic community. Clients were asked to rank the five sources of help furnished them: (1) informal contacts with project members, (2) the ad hoc group meetings, (3) regular group meetings, (4) regular counseling appointments, and (5) consultation with project staff. All ranked the informal contacts with project members

as most helpful. The one-to-one contacts with professional staff were ranked least helpful. Volunteers (who did not have regular counseling appointments) ranked the remaining four sources of help in an order much the same as that obtained for the clients. Even for such a small number of subjects our findings are statistically significant: both volunteers and clients feel that their informal contacts with project members were the greatest source of help to them.

Sociometric data gathered from all residents of the unit concerning their choices of friends and of helpers in the unit indicate the establishment of a therapeutic community. The volunteers were most heavily chosen as helpers by the clients, yet volunteers named their helpers from among clients and volunteers with nearly equal frequency. We did not find "doctor-patient type" relationships nor did we find that friendship choices separated the group into cliques of the helpers and the helped. Although volunteers were generally more popular, there were numerous mutual friendship choices among clients and volunteers. The nature of the helping relationship between volunteers and clients appears to be on an egalitarian, peer basis. It was by no means limited to reassurance and support. Members were encouraged to be open and honest with one another and to deal with deviate behavior by confrontation rather than by rejection, anxiety, and hostility. Some of the disturbed students also needed a kind of monitoring and supervision: irregular eating, sleeping, excessive drinking, and erratic attendance at class were noted and dealt with by the group as problems to be handled by the community.

As one might anticipate, the volunteers themselves had feelings of anger, anxiety, and inadequacy to cope with as a result of interacting with disturbed peers. Many of them felt they gained insight

and self-understanding as a result of being in the project. Consultation with staff as well as the regular group meeting were used to help them; and, as indicated above, they turned to one another and the clients as resource persons.

We feel that our experimental living unit shows much promise as a rehabilitation service. As we add additional cases in future years of operation we shall have a firmer basis for making such a judgment. We hope to prevent drop-outs, and to help our disturbed students to actualize their potential. Formal follow-up studies are already underway comparing the clients with matched control subjects who receive conventional services only. In this manner we should be able to evaluate whether the living unit is an effective addition to methods currently used in the rehabilitation of the emotionally disturbed college student.

Finally, a note about the acceptance of the project. Within the profession of mental health workers in the state there has been much interest in and acceptance of the project. Also, the university administration and staff have been understanding and supportive of the project in spite of some rather major adjustments required by this advent of coeducational living. Indeed, the one major problem within the administration centered not in the rehabilitation project itself but in the reconciling of the two rather different sets of rules and regulations governing men and women. Interestingly enough, the only adverse publicity given to the project was concerned entirely with the coeducational aspects of the living unit and appeared to be precipitated by an obviously well-intentioned news story written by a journalism student for the University's Collegian. A number of papers in Kansas editoralized about the dangers of coed living.

After one semester the project seems to be quietly accepted by students. An interesting and extremely valuable side-effect of the

planning for the project and its initial operation has been the solidifying of the campus' diverse mental health resources and considerable self-evaluation within the various student personnel services of the University. Communication with the faculty and university administration about the project has been facilitated by luncheons held at the residence hall and informal conversation with project staff and students in the unit. While it is too early to be sure, there is evidence that both faculty and administration regard the project not as a cloister for the maladjusted who ought not to be allowed on campus, but rather as a legitimate resource for students with problems.

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